UnitedHealthcare Community Plan of New York specialist referral form

- Patient must be a covered member at the time of service
- Referrals must be generated for in-network specialists only
- Please use this form to submit referrals for CHP HARP, MCD members
- Retroactive referrals are not accepted
- Fax: 888-624-2748
- Mail: P.O. Box 31365, Salt Lake City, UT 84131-1362

Member name: (Last, First, MI):

Member ID #: | Phone:

Date of birth (MM/DD/YYYY):

Member address:

Referring primary care physician (PCP)

Name (Last, First, MI):

PCP tax ID #: | PCP National Provider Identifier (NPI) #:

Address: (Street #, City, State, ZIP code):

Phone: | Fax:

Specialist/rendering physician

Name (Last, First, MI): | Specialty:

Specialist tax ID #: | Specialist NPI #:

Address (Street #, City, State, ZIP code):

Phone: | Fax:

continued

Referral information	
Service requested: Routine referral *1–6 visits allowed	Standing referral. Requires qualifying diagnosis *maximum 99 visits
Reason for referral:	
Diagnosis with code (ICD-10). List at least 1, not more than 2:	
(NOTE: maximum duration of 6 months) Routine referral – 1 to 6 visits Standing referral – 1 to 99 visits Number of visits: _____ If blank, 1 visit is assumed	Routine service start Date: Routine service end Date: Standing referral start Date:
Name and title of individual completing this form (only required if assigned PCP is NOT completing this form)	
Signature of individual completing this form	
Name of referring PCP	Today's date
Signature of referring PCP	Today's date

United Healthcare Community Plan